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WHY DOES A YOUNG DELINQUENT RESIST TREATMENT?

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ON A DARK moonless night some 2 years ago, 15-year-old Philip C tried to pry open the door of a warehouse. His efforts were rather clumsy, and the crowbar he used was ill-suited to the purpose. After blundering about a half hour or so, he found himself spotted by the headlights of a police patrol car. In his panic to escape he ran down a blind alley and was easily cornered by a policeman. Philip did not resist, and in short order he found himself before a judge of the children's court.

The officer in a bored monotone recited the details of Philip's arrest. The judge turned to him and in a not unkind voice said: "Well, Philip, you have heard the officer's report. What have you got to say for yourself?"

The boy, staring fixedly at the floor, and without even looking up, sullenly muttered: "I didn't do it."

The officer's color deepened perceptibly, and the judge became a little less kind.

"Come, boy, you were caught in the act. Lying will do you no good."

Philip paid no attention. Nor was there any significant change in his demeanor at the detention home or during the course of the probation officer's investigation. He was sullen, evasive, and untruthful in his insistent denial.

At the diagnostic service our first glimpse of Philip provided us with no easy explanation of his puzzling behavior. He was neither psychopathic nor psychotic. He had the capacity for moral judgments, the emotional equipment for experiencing feelings of guilt and anxiety, and an intelligence adequate enough to perceive that it might go worse with him if he persisted in his "uncooperative attitude." But persist he did, and in a way that seemed to promise considerable resistance to any therapeutic endeavor.

Whatever a child's neighborhood, its sights and sounds have the familiar feel of home.

Mrs. C, Philip's mother, on the other hand, seemed more helpful. She proclaimed herself ready and anxious to assist the clinic; said she had suspected that Philip had been stealing, and now, alas, he was beyond her control. Mrs. C said that she had tried hard, since her husband's death, to bring up Philip as a good boy, but despite her efforts he had begun to play hookey. But that wasn't his fault; the school was bad. It was overcrowded and the teacher took no interest in a boy like Philip, who maybe needed a little extra attention. The teacher was mean to him and that was why Philip refused to go. He wasn't

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Dr. Peck has based this article on the paper he gave at the seventy-seventh annual meeting of the National Conference of Social Work.

really a bad boy; it was just the kind of tough crowd he had gotten in with in the neighborhood. It was a bad neighborhood. She would like to move out, but what could she do on a relief budget and apartments so hard to get? Nevertheless she would be glad to cooperate in any way the clinic wanted her to.

I have tried to sketch for you the bare outlines of the sort of case familiar to any agency that sees delinquents and their parents. Even with such meager information as this, the skilled worker might well hesitate to accept the C's for treatment. An agency that attempts to select persons who seem most capable of utilizing its therapeutic services might well be concerned about the difficulties likely to be encountered in the course of treatment for either this boy or his mother. The boy, by denying what he did, certainly offers little basis for a relationship designed to explore either his present difficulties or his other life problems. His mother, ostensibly so anxious for help, is overprotective of her son and at the same time denies all responsibility, placing it on schools, teachers, relief, and so forth. Much of her story is undoubtedly rooted in truth, but she is using it to evade any involvement in her son's treatment.

If an agency accepts a case such as this, it is likely that both mother and child will frequently miss appointments; that the mother will adhere tenaciously to externals; that the boy will enter upon prolonged sullen silences and will probably continue his delinquencies. Such a case might well be considered unsuitable for treatment by the judicious intake worker, who discerns the strong defenses that the mother sets up in denying her role in her son's difficulty and the boy's seemingly irrational protestations of innocence. The resistances —we say—the resistances are too great.

It isn't only boys that have a sense of belonging to their block; girls have it too.

I have begun to suspect that if in saying this we refer only to the defenses against treatment that exist in the patient's unconscious, our statement is only half the truth. For I am coming to believe that we cannot speak of the resistance of people like Mrs. C and her son without at least examining the resistance in ourselves if we assume the responsibility of being helpful to them.

I will not quarrel with those who prefer to examine these questions in terms of the inflexibility of certain of our treatment agencies in their approach to the delinquent and his family. An analyst, on the other hand, who encounters frequent failures with certain types of patients does not hesitate to search for inner resistances within himself, which he may suspect of being at least partly responsible for certain of the obstacles encountered in treatment.

When I speak of the resistances that are present in both agency and client in the field of delinquency, I refer to certain defects in our approach to the delinquent, which seem to be almost deliberately contrived to foster rather than to resolve the problems of inaccessibility so noticeable in the delinquent and his family.

The relation between delinquency and deprivation is reflected in the high incidence of delinquency in community areas that lack adequate housing, school, recreation, or medical facilities. In the treatment of individuals the plan is not formulated on the basis of symptoms but rather in terms of the underlying dynamic needs. So as we progress in our understanding of the complex relation between the individual delinquent and the defects of the community, we must inevitably move toward remedying these defects rather than continuing our fruitless attempts to resolve an unending series of critical situations.

By the time the delinquent's disturbance has progressed so far as to bring him into trouble with the neighbors, or the school, or the police, he usually shows a marked distortion in his relationship with authority. Authority is brought close to him not only by a judge or a probation officer, but even by the seemingly friendly and well-disposed case worker who sits across

the desk smiling her most permissive smile. It seems, then, like asking for unnecessary trouble to attempt to approach the delinquent in settings that are likely to bring on almost invincible resistances at the very outset of treatment.

Workers have recognized for some time the therapeutic advantages to be gained in meeting the delinquent at places to which he comes spontaneously and where his initial encounter is with people not associated with his unpleasant experiences with authority. Our experiences in the use of group therapy as a method of treating delinquents and their parents at the New York City Court of Domestic Relations lead us to believe that most children are better able to tolerate adults when they have the support of a group of other youngsters. A group tends to dilute the intensity of face-to-face relationship with an adult, a situation which is sometimes unbearable to children with critical disturbances in their relationship with authority.

Such thinking about treatment approaches may well be irksome to persons who have already attempted to meet the problem of delinquency within some of our traditional community and group-work settings. They point out, and correctly, that the persons most in need of attention are precisely the ones who are apt not to be helped at a playground, a community center, or a parents' discussion group. The families that ultimately appear in court are likely to be the ones that do not attend such agencies, or if they do come, may drop out or even be forced out because they are disruptive elements within the groups usually available to them. This problem, however, is not an insoluble one unless we permit our resistances to make it so.

For if we agree that we ought, wherever possible, to change the kind of settings in which we treat delinquents, to move from the formal confines of the court or traditional case-work agency to the community center, playground, hospital clinic, vocational agency, then we, who are especially qualified to give treatment, cannot at this point wash our hands of the whole business. We cannot say "This is not our job." We cannot justify our deserting the delinquent, with the excuse of poor outlook, until we have taken the necessary steps to reduce the large number of treatment failures in this field. Our failure to take these steps is a symptom of our resistance against extending ourselves beyond the habitual patterns, the traditional confines of our agency structure.

Thus, the delinquent, who is so often the scapegoat of the disturbances within his family, is forced to bear a double burden. He not only suffers for the community's failure to provide satisfactory resources to help him grow and develop normally, but in addition he is rejected and neglected in the distribution of services required to repair the damage already done to him.

If this state of affairs is to be altered we shall have to begin now to revise drastically many of our present ways of approaching delinquents and their families. I believe it is essential to any such revisions that we stop regarding the delinquent as someone whom we must keep from doing an undesirable act. Rather our emphasis must be on providing services within certain areas of our community with a view to meeting the needs of deprived individuals within such areas. Agencies whose operation seem to be dictated by policies of "sit and wait — let them come to us," must critically reexamine their attitudes. We have already discarded such attitudes in the field of education and public health, and they most certainly have no place in a comprehensive community program against delinquency.

Such a comprehensive program is envisioned in the work of the New York City Youth Board. The functioning of this agency is unique in a city remarkable for its vast conglomeration of private and public agencies. The basic premise on which it operates is an acceptance of community responsibility for providing for the unmet needs of children — not only children who get into trouble, or children whose parents ask for help, or families who are "accessible" to treatment — but merely children with unmet needs.

A significant characteristic of the

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Neighborhood activities, good or bad, mean much to the youngsters who take part in them.

MICHIGAN LOOKS TOWARD COORDINATING ITS WORK FOR CRIPPLED CHILDREN

Physical and occupational therapists meet with other professional workers to discuss joint problems

JESSIE F. WADDELL
MARY A. BLAIR

MICHIGAN occupational and physical therapists have taken a long step toward bringing together the many types of professional workers who serve crippled children.

Members of these two groups joined in a State-wide conference for the first time 2 years ago, and met again last year. In 1951 they progressed to the point of including in the conference some others who work with crippled children—physicians, teachers and school officials, nurses, social workers, and speech therapists — to discuss with them a closer coordination of the various types of work they do for the same patients.

To coordinate services

At all three conferences the members discussed not techniques of actual services for crippled children, but rather how to make such services more effective. They sought ways to promote continuing service after the child's discharge from a hospital.

They urged that everyone concerned learn more about the resources that can be used to help a child in his own community. They compared methods of obtaining equipment for use in functional training for crippled children, and of keeping this equipment in repair.

They made suggestions for recruiting young people for occupational and physical therapy, in an effort to overcome the shortage of therapists that intensifies many of the other problems discussed. They exchanged views on achieving closer relations among all professional workers in fields concerned with children.

How did physical and occupational therapists get this chance to ask the questions that demanded answers and to work out suggestions for united action in local communities? They long had wanted some way to discuss their day-to-day problems together. But a gap separated occupational therapists from physical therapists, although they have similar perplexities. Each specialty had for years held its own professional meetings; but no interprofessional meetings came about.

Realizing the need, the Michigan Crippled Children Commission, the official State crippled children's agency, took constructive action. Along with the State Department of Public Instruction, it arranged for an interprofessional meeting in 1949, for an interchange of ideas. This led, step by step, to the 1950 and 1951 meetings. The Michigan Society for Crippled Children and Adults and the National Foundation for Infantile Paralysis assisted the two sponsoring agencies in their project.

Because the meetings were planned to be informal, the setting chosen for the whole series was a rustic lakeside lodge in the woods of Northern Michigan. The State Conservation Department maintains this lodge for in-service training of its staff, and makes it available for meetings of this kind.

Members of the first two conferences of the series, held in 1949 and 1950, were (1) staff members of the sponsoring agencies, (2) occupational and physical therapists who work in local communities throughout the State, (3) therapists from schools and convalescent homes, and (4) representatives of other State-wide and local agencies dealing with services for crippled children. The 1951 conference included also members of the other professions whose skills serve crippled children.

In order to have the necessary consultant services available when the discussants needed them, the sponsors arranged for specialists in various professions to come to the meetings as advisers. Their expenses were paid by the Michigan Crippled Children Commission. At the 1949 meeting the advisers were (besides the staff members of the sponsoring agencies): The medical director of Region V, Children's Bureau, of the Federal Security Agency; a member of the Joint Orthopedic Nursing Advisory Service who is now polio consultant of the American Physical Therapy Association; the director of the Bureau of Ma-

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ternal and Child Health of the Michigan State Department of Health; the chief physical therapist of the Sigma Gamma Hospital School, a convalescent hospital; and a college instructor who has had experience with the processes of group dynamics.

The leader in group dynamics was there to introduce the conferees to a way of discussion that makes it possible, in fact necessary, for all members of the conference to take an active part in the organization of the meeting and an articulate part in the discussions, a way that is intended to make them practical, definite, and fruitful.

At the suggestion of the leader, the members divided into random groups of about seven each, and elected a chairman and a recorder. After the small groups had defined the problems they wanted to discuss, the recorders met and listed the problems in suitable classifications, and presented them to the conference as a whole. Then the members of the conference regrouped themselves, each one joining the work group that was to consider his particular set of problems. Each work group elected an observer, as well as a recorder. This observer, as a member of the work group, looked at its work objectively, and later reported his observations to the conference.

This method of discussion was used in all three conferences. Each of the first two had about 50 members, but the third, enlarged to include other professions, had 67 members. A fourth conference is to be held in 1952, again drawing its members from various fields of work for crippled children.

What volunteers can do

Each year the discussions centered around the problems of "O. T.'s" and "P.T.'s" and how they can work toward solving them. The other professional members of the third conference made suggestions about this from their own points of view.

Here are some of the subjects that were considered, and a few of the suggestions made in the course of the discussions:

How to make the best use of volunteer service was one topic. The discussants agreed that volunteers should be selected carefully for their skills and reliability, and that they should do supplementary work only, under the close supervision of a therapist. Before they start, they should receive training for what they are to do.

In "O.T.," volunteers can be selected from groups familiar with craft work, members suggested, such as scout leaders, home-demonstration agents, hobbyists, art teachers, and Red Cross craft workers. In "P.T.," volunteers can be chosen from physical-education instructors, inactive nurses, and Red Cross nurse aides. These prospective volunteers should be found and listed in each community.

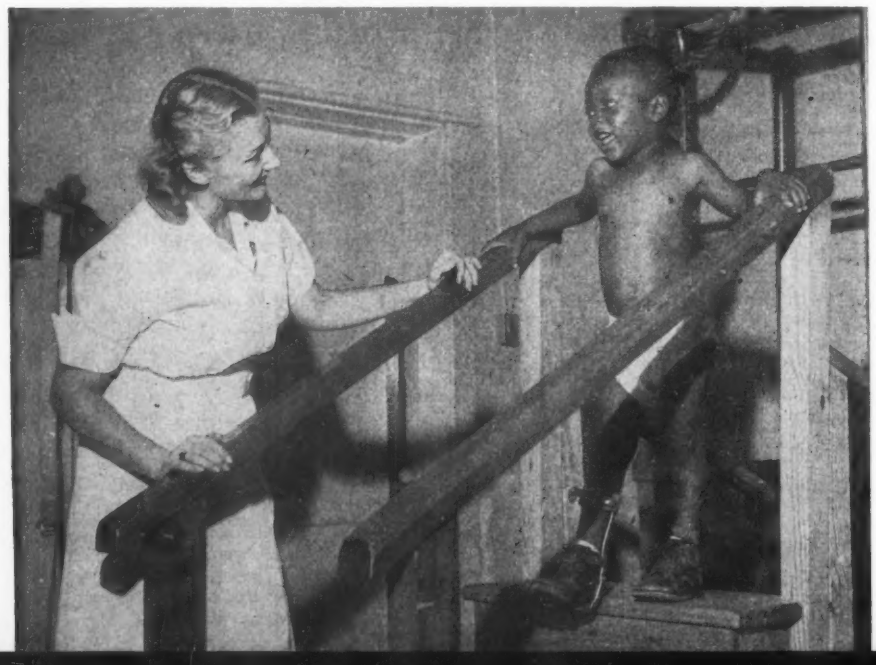
Other volunteers, without the qualifications of those just mentioned, might give recreational service to children with minor handicaps. They could be chosen from outstanding men and women who are interested in offering their services because they are already connected with some social or health service for children, usually as members of boards of directors. They must be willing, of course, to accept instructions and advice about their work from the therapists.

Homebound children get a chance for fun

Businessmen's clubs in many communities have shown interest in giving crippled children who are homebound opportunities for fun, some members pointed out. These volunteers give picnics and parties for the children; they arrange trips and camp outings. They supply tickets for ball games or the movies, providing the transportation necessary. They may supply severely disabled patients with machines for book projection. Members of these clubs may go to the children's own homes to play games with them or to show them motion pictures.

Running through many of the discussions was the thought that occupational and physical therapists should strengthen their lines of communication with those they work with — particularly with physicians and parents. A few ways to do this were mentioned, as, for example, by helping interns, through staff conferences, to become aware of the services that physical and occupational therapists are prepared to give, and by being careful not to assume responsibility beyond their professional competence. Therapists could inform parents, it was said, of the services that public funds provide for crippled children. This could be done through various mediums.

This little boy should continue to have physical therapy without a break until the doctor discharges him, that he may benefit fully from the skilled care he has received so far.



As soon as Ruth left the hospital, her physician gave the occupational therapist orders for helping her to develop certain muscles. The therapist sends him regular reports.

One work group considered how to improve the follow-up by physical and occupational therapists of children who have had acute poliomyelitis, so that the children get therapy sooner and more continuously. Some members suggested that therapists inform the medical profession of the services available from therapists in the local communities throughout the State, and that therapists get into contact with each child's physician at regular intervals to report the child's progress. Other members wanted the therapists to ask that specific orders from the physician who is discharging a child be transmitted through established hospital channels to the therapist who is to work with the child. (Since the conference, a form has been worked out on which the National Foundation for Infantile Paralysis reports to the Michigan Crippled Children Commission the discharge from the hospital of children with polio whose care has been financed by the Foundation.)

One very practical question became the subject of a year's survey. The question was: Where and how can physical therapists get the "P. T." apparatus and equipment needed for individual children in order to start therapy immediately after receiving the physicians' orders? The work group decided not to try to make suggestions on this at the conference, but to keep the group intact and to continue to search for information. It planned a survey to determine the need for pooling equipment and to find out what equipment is being used and what patterns and ideas for equipment are available. The therapists were to do this work with the help of physicians and engineers. The aim was to find out about adjustable prefabricated apparatus that would be reasonable in cost.

When the therapists wondered what they could do to improve coordination of services for crippled children in a community, they received these suggestions: You should affiliate with the council of social and health agencies in the county or other community in which you work. In addition, you can arrange for meetings with members of allied professions. To make discussion with these workers practical, it is good to begin with the case of one specific child, the group agreed.

The question that comes up in almost every professional discussion of making services more effective did not fail to come up here: What can we do about the extreme shortage of qualified therapists? How can we increase the number of "O. T.'s" and "P.T.'s" in civilian service? Among the suggestions the work group made about this problem were these:

In order to get more young people interested in occupational and physical therapy as a career we should reach junior and senior high-school students. We should make contacts with superintendents of schools, school principals, and especially with school vocational counselors. These counselors should be informed about all phases of the qualifications necessary for entering the work.

Therapists can help to develop recruitment teams made up of staff members of hospitals, schools, clinics. These teams would work to get information to young people about to decide on their technical training after graduation from high school. "Career days" in high school are an excellent opportunity for such teams to get their message heard.

To give young people a chance to see in action the work they are hearing about, some hospitals, clinics, and orthopedic schools might arrange to show the work in operation to a group of students.

Scholarships bring recruits

Therapists, it was suggested, should collect copies of printed matter describing their occupations and distribute them to schools and to public libraries. In addition to making the most of informational material already prepared, they should work toward having a film made for the purpose of recruitment.

Establishing scholarships for the training of young persons in "O.T." and "P.T." is a sound long-term method of recruitment.

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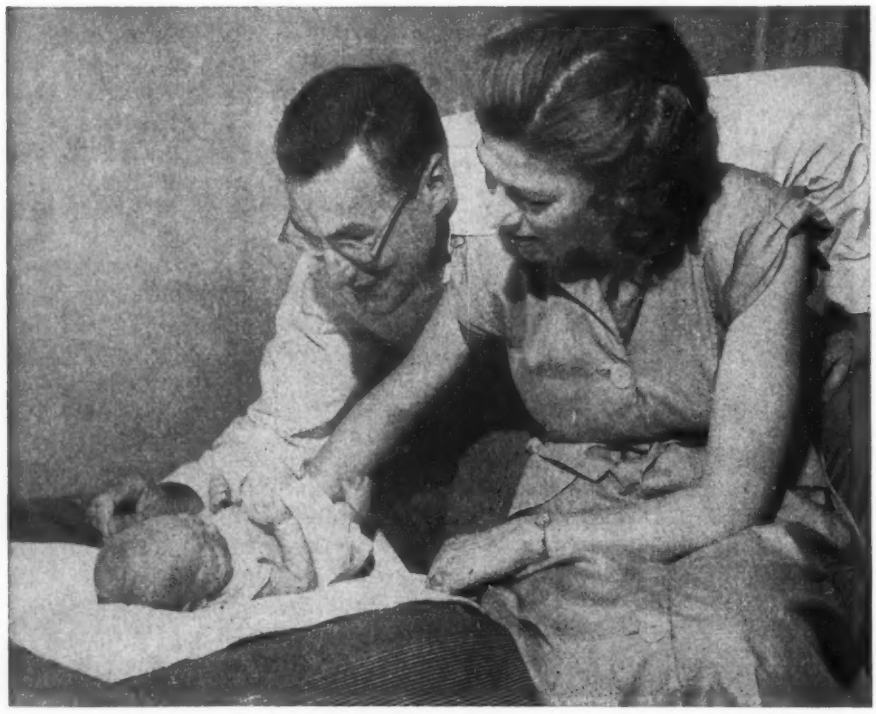
IF A BABY IS TO BE ADOPTED

How early should we place him in his new home?



MARY ELIZABETH FAIRWEATHER

FEAR of the unknown is a basic human characteristic of which case workers practicing in the adoption field have their full quota. Constructively used this fear can be a powerful incentive to careful study of the child, the natural parents, and the adoptive parents, which will transform the unknown to the blessedly secure known. Used otherwise, it can inhibit further learning.

As understanding of case work increases, generously supplemented by expanding knowledge in related fields, we who work in the field of adoption realize better, and have more respect for, the responsibility we assume in taking part in the permanent uniting of human lives. This respect is wholesome and necessary. It helps us to recognize dangers, and it convinces us of the necessity for greater exploration of unknown areas.

As a result of our sobering realization of the tragedies that can stem from badly put-together lives we have tended to remain within the protection of tested and tried methods, bolstered by all the scientific information at our command. This, too, is good in a profession that recognizes its youth. But if we are to grow, is it not high time that we take stock of the things we already know, face honestly what we do not know, and move together toward greater enlightenment by carefully observing our experience, our experiments, and their pooled results?

Inevitably, adoption practices are now uneven. Some of us have hewed closely to conservatism; others already have begun pioneering. The resources at our command are not evenly distributed, but our concerns are the same.

Let us take a glance at some of the territory we have covered and then let us train our sights on the country ahead. We may be sure that in any forward journey we

shall have valuable companions. There are psychiatry, pediatrics, and psychology, with their growing knowledge of human personality and of healthy, maturing growth, and their tested standards for various stages of development. There are sociology and anthropology, with their contributions to the understanding of cultural patterns.

We can all think of others; but let us not forget our most vitally interested contributors, our adoptive parents. And let us not forget, either, the contributions of those unwelcome but ever-present attendants, the independent and — yes— the "black-market" practitioners. They, too, can teach us something by making us ask ourselves why so many unmarried mothers, and couples, who wish to adopt a baby turn to them.

Adoption workers influence human lives

Historically, social work has been concerned with the needs of the individual in relation to his environment. For many years our efforts were confined largely to our attempts to manipulate the environment to the greater advantage of the individuals about whom we were concerned. This is, and will continue to be, a major and respected responsibility of social work in general, and case work in particular.

Gradually, however, as psychiatric knowledge is applied more and more, we are learning about the effects of inner stresses upon the individual, and on his reaction to his environment. Our diagnostic skills are of necessity focused upon recognizing both inner and outer stresses, and their causes.

In no other aspect of social work does the case worker have such unlimited possibilities for selecting the environment of an individual as does the adoption worker. And if we believe that the personality, with all its emotional components, is largely shaped by the environment that nourishes it, then in the early placement of infants we must see an opportunity for skilled case-work services that is almost overwhelming in its significance.

It is, of course, this power to influence the lives of human beings that scares us and sends us scurrying for all the support and assistance our own and related professions can give us. Again, it is well that we are scared. It is well that we view this responsibility humbly and with awe. It is well to the degree that it produces in us an unquenchable thirst for greater and deeper wisdom upon which to form our judgments and discharge our responsibilities. It is well to the degree that it drives us to keener observation of facts, so that from pooled experience we can form a whetstone on which we can continually sharpen our skills. It is not well if this same fear reduces us to immobility and the overcautiousness that keeps us from careful experimenting and the ability to learn from it; if it blinds us to the significance of new knowledge in our own and allied fields.

For purposes of this discussion I should like to consider "early placement" as meaning placement of babies under 3 months of age. We know that comparatively few of our agencies are placing babies younger than that. Why? Because they know of families that accepted infants shortly after birth and have subsequently found that they had serious physical or mental impairments. This not only has given us cause for thought (as well it should) but has stopped some of us in our tracks with what appears, occasionally, to be permanent paralysis.

Because of those unfortunate placements we have wisely sought more careful and accurate advice from medicine and psychology. But have we always made full use of this advice? Medicine, for instance, tells us that there are comparatively few serious physical abnormalities at birth that cannot be detected in the first few weeks. Perhaps we have given undue weight to those comparatively few possibilities. We know that psychology is making rapid strides in testing. Are we keeping up with the psychologists?

Knowing full well the dangers of blind placements, we have looked down our noses at those who make them. Struggling to offset the evils of such placements, we have brought fear psychology to bear in appealing to the self-interest of couples who wish to adopt a baby, by saying: "Come to an agency so that you can be assured of mental and physical adequacy in your child!"

What causes adoption failures?

Can we ever really guarantee this? And if we could, is this, or should this be, the primary function of sound adoption practice? And has this stopped or even slowed up the black-market and independent placements? The answers are all too clearly written, first in the statistics of adoption courts, and later in adoption failures recorded in family agencies, guidance clinics, juvenile courts, and mental hospitals. Are these failures due to mental or physical inadequacies of the child? Not predominantly. They are due usually to inadequate parents or inadequate help in the adjustment process.

Is it not time that we put our emphasis on other areas of our knowledge and concerns? Listen again to some of our other sources of advice: to psychiatry, to our own experience, to the adoptive parents themselves.

There is a triangular motif that runs through the design of all human life. Freud and his disciples point up its outlines in tracing the dynamics of emotional growth. Helene Deutsch, in her study, "The Psychology of Women," discusses a

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This article is condensed from a paper Miss Fairweather gave at the seventy-sixth annual meeting of the National Conference of Social Work.

woman's profound need to love her child in a family triangle. Whether balanced or distorted, this triangle influences every psychiatric consideration of human experience from infancy to the grave.

In a sense, adoption practice is framed by another triangle, with the child as the apex and with the sides made up of his own parent or parents, the adoptive parents, and the agency. We have had the apex under the microscope for some time now and this is well, for we still have much to learn. But I suggest that if the apex is to be supported adequately the sides must be kept in balance and strengthened by our understanding.

We learn from other fields

Reiterating my appreciation and admiration for what psychology has contributed, and promises to contribute, to the field of adoption, I believe we need to make careful use of everything it can offer and to be fully alert to its continuing contributions. But what of our other obligations? What of our other counselors?

What, for instance, does psychiatry tell us about early infancy? There is as yet no complete agreement about the significance of constitutional factors in the development of personality, but no one underestimates the influence of environment on these factors. I do not need to remind you of the constantly mounting studies that show the influence of family relationships from the moment of birth and the role that consistent mothering plays in the optimum development of the infant, not only physically, but emotionally and mentally as well.

Dr. Margaret Ribble, in "The Rights of Infants" points up the importance of the first 3 months of life in this respect and the damage that can be done to a child if mother love is lacking. Dr. Leo H. Bartemeier and his associates, who formulated the idea of the Cornelian Corner, emphasize the advantages of earliest possible mother-child relationship. Doctors Arnold Gesell and Catherine S. Amatruda, in "Developmental Diagnosis," point out that children in faulty homes and in institutions are often retarded. Many psychologists expect children brought up in institutions to rate lower than their true potential levels. This is shown when the child is tested again after adoptive or foster-home placement. We have abundant evidence from our own experiences of how children who have been severely hurt emotionally can blossom if they are given love and security. We can and should obtain more scientifically compiled evidence of this, which is well known to every adoption worker. But we can never hope to measure how much more might have been attained if the hurt had not occurred.

We know that the very circumstances that make a baby available for adoption fill his earliest environment with conflict and rejection. We know how adequately and joyfully an adoptive couple, capable of healthy parental feelings, can meet a baby's needs in a way that is beyond anything we can hope to offer through other kinds of foster care.

First adjustment is all-important

Looking at the adoptive parents, psychiatry underscores our conclusions by recognizing the importance of the complete dependency and helplessness of the very young infant as a factor in laying firm foundations for parental feelings in the adoptive family. We know the injury that change can cause to a child, and its effects upon his adjustment even in a happy placement. We know the disturbing effect a child's difficulties in eating, sleeping, and so forth, have upon adoptive parents, particularly the mother, and the vicious circle this can set up in the all-important first adjustment. This has urgent significance, not only in planning for early adoptive placement but, where this is not possible, in planning for individualized rather than group care for infants.

Listen to applicants for a baby to adopt. "How early do you place?" "We want as young a baby as possible." "We are not afraid of taking some risks; we'd take some risks if we had a baby born to us."

Look at the throes of "psychological labor," always present at the time of placement. Aren't they lessened by the aspect of a young and helpless infant whose features have not developed the distinctive characteristics that have to be reconciled with those of the omnipresent fantasy child?

The coming of a child into an adoptive family has been described as a rebirth. This is not just a figure of speech. It has deep psychological reality. The birth pangs for both adoptive parents and child are notoriously greater in direct proportion to the age of the child.

Listen to adoptive parents who have had their baby from the first few weeks of his life: "Already he seems like ours. We know we can help him develop his personality as well as his physical powers and in that sense we are creating him and he is really ours."

Look at the majority of children placed by "black markets" and independent agents. In what age group do they fall? Infancy, of course. Why?

But what about protection? Well —what about it? Whom are we protecting by delaying placement? Is it the child, who is our paramount responsibility? According to psychiatrists, no. Is it the adoptive parents, whom we have chosen because of their indications of maturity, good life adjustment, and mutual happiness? Not usually at their request. Is it the child's own parents (frequently the unmarried mother), who have not found a more ready and willing answer through the "black market" or other independent sources? Psychiatric and our own case-work literature are filled with warnings of the neurotic conflict that may result from delayed decisions.

Here, again, is the adoption triangle. Our responsibility for protection lies within it, but that responsibility is not usually discharged

in the best way by delayed placement of the child. When careful social diagnosis indicates adoption for an infant, we must remember that the welfare and protection of all concerned are inextricably interwoven. And I believe that their best interests are served by the earliest possible placement. Let us concentrate less on our fears of unknown factors in a child and try harder to develop greater ability to know our adoptive applicants and to realize what they can offer as healthy, nutritive soil in which a new life can develop. Normal, well-adjusted adults, given the opportunity, can weigh the risks of reasonable unknowns, arrive at a decision, and find a healthy way to adjust to the results of their decision. Basic case-work principles proclaim that the adoptive parents have a right to this kind of self-direction. If our professional evaluation has been sound we have no need or right to overprotect them.

Our energies might be spent to better advantage in careful case-work services to natural parents in helping them reach an early and clear decision when adoption is indicated; in helping them to give as complete and accurate information as possible about their babies' backgrounds as one of their contributions to this plan. Between the natural parent and the child placed for adoption there is a psychological as well as a physical cord to be cut. If it isn't carefully and skillfully cut at the appropriate time it can be a permanent threat to the security of any adoption placement.

We must know ourselves

And our energies might be spent better in looking at ourselves. Are we making full use of the professional knowledge and advice available to us? Are we training our workers to know the boundaries of normal development in children so that their observations can supplement and assist those of our consultants? Have we the courage to discharge the responsibility we have assumed? Or must we share our doubts and fears of the unknown as well as our knowledge of pertinent facts? Have we the courage to face squarely our inevitable areas of inadequacy? And can we derive from them the stimulation for increased efforts to widen and deepen our knowledge and for greater sharing of the results of our efforts?

I recognize that there always will be situations in which delays are inevitable. We shall always have the older child to place. That is another topic and a challenging one. But when we can, let us place the baby early. Let us by all means make use of every available tool to increase our knowledge and to guide the adjustment of child and family. Where justifiable doubts are present, let us have serial tests made.

But why can't these tests be done more often in the adoptive home, with adequate preparation and interpretation given to the parents? Why would it not be feasible some day to have psychological tests given to all babies as are physical examinations? Why cannot these tests be viewed as an early step toward vocational guidance rather than as a measurement of abstract adequacy? Do not healthy, well-adjusted parents want primarily the optimum development of their children within their capacities?

Science indicates that individually our maximum capacity for mental development is fixed at birth, but that our chances for achieving it are modified by our later environment. We now believe that even intelligence quotients can be raised, in an adequately supportive and stimulating climate. Those of us in adoption work have held front-row seats at many of these performances. We have evidence that emotional quotients have no such prenatal roots. Fortunately, high intelligence quotients and high emotional quotients are not mutually exclusive; but neither are they necessarily correlated. We in adoption work are today selecting the soil that will nourish many of tomorrow's emotional quotients. Here at once is the adoption worker's deepest responsibility and greatest challenge.

Reprints in about 6 weeks

DELINQUENCY

(Continued from page 36)

Youth Board has been the intimate interrelationships that it has evolved in its work with a great variety of widely differing agencies. Recognizing that delinquency is not a single problem but rather a complex of problems, with aspects in the fields of health, welfare, psychiatry, group work, and education, the Youth Board has not hesitated to call upon any resource in the community that touches its job of providing services for children whose life situations are thrusting them into delinquency. This has meant a considerable broadening of the case-finding process. Also, the Youth Board's research into area distribution of delinquency calls for obtaining involved and detailed knowledge not only of the statistical, but also of the cultural, variations among the various areas of the city.

The Youth Board's approach has emphasized that the intake process is also a reaching out. The concept of reaching out should be an essential part of any program that offers treatment services to people whose previous experiences have intensified their feelings of defensiveness and suspicion toward those who ostensibly are interested in helping them.

All of us must be sharply aware of the tremendous advantage enjoyed by a worker who is able to offer service in a way that is acceptable to the client. The experienced case worker is aware that one may visit the client's home, community center, or neighborhood without seeming to intrude, if one acts with a real respect for the integrity of the client, and if one is prepared to assume the responsibility of offering the kind of substantial services implied in such overtures. These services must not only be nominally available but actually accessible to those who might require them.

I believe that an approach of this kind may also carry with it a pos-

sible solution to some of the problems of obtaining adequately trained personnel to meet the increased burden thrown upon available treatment resources by any such comprehensive program as that of the Youth Board. I believe the step we should take is to transfer the functions of selected treatment personnel to community agencies such as schools, playgrounds, and community centers, in high delinquency areas.

If such personnel are used both in participating and supervisory capacities it may be possible to add to our treatment resources in a way that may be more effective and economical than merely creating new treatment agencies, remote from the settings accessible to our prospective clients.

I understand that the New York City Youth Board is studying the possibilities of further development of its program in this direction. If this can be brought about, we may, for example, be able to introduce therapeutically oriented services into a parents' group at the school attended by young Phil C, whom you met at the beginning of this paper. It might be possible then to bring his mother into treatment without bringing on her resistance. And it might then be less important for Mrs. C to shift the entire blame onto the defects in her life situation.

As for her son Phil, can there be much doubt that he would be more responsive if approached within his neighborhood by a worker who is part of that neighborhood? And could we not provide for him a classroom experience guided by a teacher similarly oriented?

Are we the ones responsible?

Such arrangements are not easily made, and yet unless we make provision for them soon we shall have to acknowledge that when a boy like Phil insistently denies his guilt, he may be right. Perhaps **he** did not do it and maybe **we** did. It is just possible that it is about time **we** started doing something about it.

Reprints in about 6 weeks

CRIPPLED CHILDREN

(Continued from page 39)

A teacher in the group said that therapists, like others whose work is not well known by the public, can lay foundations for recruitment while working on their own jobs. A good piece of work can make the patient, his family, and his friends a potent source of enthusiasm that may direct vocational interest toward this field.

One member suggested that if each practicing therapist would make herself responsible for bringing one young person into her field as a trainee, the number of recruits would be considerable, and they would start with a good idea of what to expect from such a career.

Problems that therapists encounter when they work with crippled children in school were threshed over. How can these children be assured the physical or occupational therapy they need? This question was asked in one of the groups. After considering the question, the group urged that full instructions from the physicians for treatment be in the therapists' hands within 2 weeks of the child's admission to school.

When crippled children go to school

Have therapists a responsibility about the program in an orthopedic school? Yes, the group thought. Therapists should take part in planning the whole school program if "O.T." and "P.T." are to be properly integrated in the children's schooling. Furthermore, they should attend regular staff meetings and should take part in the work of school committees. Case conferences might be held, the group felt, with all staff members present who are interested in the problems of the child to be discussed. If the best possible school program is to be worked out for a child, information about him must be pooled from all sources, that is, from all who are concerned with his care or his education.

That parents of children in orthopedic schools at times need reassurance from outside the home to help them play their part in restoring the child to health, was also discussed in this same work group. The group suggested that the parents come with their child when he enters school, to learn the school set-up; that parent-teacher conferences be organized and also institutes for fathers and mothers, which parents and child may attend together. If necessary, visits can be made to the home for the purpose of getting in closer touch with the mother and father. These visits may be made by any of the professional workers concerned with the child.

The group suggested also that clubs be organized for mothers and fathers of children with special difficulties, such as cerebral palsy, and that open-house demonstrations be held for parents, so that they can see treatments in progress.

Joint discussion proves helpful

At the end of the third conference, the members looked back to see whether they had benefited from the series. They saw that they had grown somewhat in ability to take an active part in discussion and in arriving at conclusions. But their greatest gain had been in achieving some closer relations. The therapists tended to isolate themselves less as "O.T.'s" and "P.T.'s". All the members of the conferences came to feel that they were parts of an alliance, working with a common aim, even though their services to crippled children were distinctly different. School people, for example, came to understand much better the problems of a handicapped child in his home, and other specialists learned about what is done for him in school.

This series of conferences for occupational and physical therapists was, of course, based on the services for crippled children in one State only, Michigan, but the idea of the conferences could be adapted to the plans for this program in other States.

Reprints in about 6 weeks

IN THE NEWS

To uphold child labor standards

All employment of minors on military installations shall be in compliance with State and Federal labor laws. This is the policy of the Defense Department, as restated August 1, 1951, in a memorandum from Assistant Secretary of Defense Anna M. Rosenberg to the Secretaries of the Army, the Navy, and the Air Force.

This action was taken after discussion between representatives of the Department of Defense and of the Department of Labor's Bureau of Labor Standards. The latter had received a number of complaints from State labor departments to the effect that children were being employed on military installations contrary to State child-labor standards and that this employment was interfering with their school work.

The memorandum from the Assistant Secretary of Defense pointed out that the health, education, and well-being of children on military installations and reservations is a responsibility of the Department of Defense, to be discharged by commanding officers. This responsibility includes obtaining assurances that employers on such installations and reservations will comply with Federal labor laws and with State or other governmental labor laws that would normally apply except for the fact that the area is under Federal jurisdiction.

This means that Federal and State labor laws are to be observed in the employment of children in all activities at military installations or reservations, including, for example, work for concessionaries, officers' messes, military and civilian clubs, commissary stores, exchanges, motion-picture and recreational services, and groups engaged in the sale and distribution of newspapers and candy.

The Secretary of the Army, in a memorandum of August 9, 1951, has reminded all commanding generals of this policy and of his desire that they extend full cooperation to State and other officials who bring to their attention any child-labor problems.

The Bureau of Labor Standards has advised State labor commissioners of this restatement of policy and has suggested that they deal directly with the commanding officers with regard to any child-labor problems that may arise in connection with work on military installations and reservations in their States.

Interagency conference studies personality

At the request of the Federal Interdepartmental Committee on Children and Youth, the Josiah Macy, Jr., Foundation sponsored the Interagency Conference on Healthy Personality Development in Children, which met at Princeton, N. J., September 21–25. At this conference members of the Interdepartmental Committee met with outstanding social scientists, psychologists, psychiatrists, and physicians to consider the implications of White House Conference findings for Federal programs concerned with children and youth.

Co-chairmen of the conference were Dr. Frank Fremont-Smith of the Foundation and Katharine F. Lenroot. Miss Lenroot will edit the report of the proceedings.

Midcentury Committee moves to New York

The National Midcentury Committee for Children and Youth, which has been located in the Federal Security Building, Washington, D. C., is now at 160 Broadway, New York 7, N. Y.

The committee is a Nation-wide voluntary organization created to work toward achieving the objectives of the Midcentury White House Conference on Children and Youth.

More crippled children served

About 215,000 children received physicians' services under the State crippled children's programs during the fiscal year ended June 30, 1950, according to preliminary estimates. This number is 18 percent greater than the number that received such services in the preceding fiscal year (181,000), which in turn was 17 percent greater than the figure for the year before that.

The physicians' services were given in clinics, hospitals, convalescent homes, and elsewhere, mainly in a physician's office or the child's home.

The children who received these diagnostic or treatment services from physicians during fiscal year 1950 were also served by nurses; medical social workers; nutritionists; physical, occupational, or speech therapists; and other personnel making up the "medical team" for a crippled children's program.

In each of the 3 years some children not included in the counts given above received services from one or more members of the medical team but were not seen by a physician. In the fiscal year 1950 there were an estimated 30,000 such children. Taking these into account, the total number of children who received some professional services under the crippled children's programs during 1950 was about 245,000. The corresponding total counts for 1949 and 1948 were, respectively, 207,000 and 175,000.

Most of the 215,000 children who received physicians' services in 1950 were seen at clinics at some time during the year. Averaging two visits each, 180,000 children visited clinics. It was clinic services that accounted for most of the increased number of children served by the program in 1950. Almost 30,000 more children attended clinics in 1950 than in 1949, which in turn had shown a 20,000 increase over 1948.

For child health in Asia

A $20,000,000 program to improve the health of the children of Asia—half of all the children in the world—is now being conducted by United Nations International Children's Emergency Fund (UNICEF).

An antituberculosis vaccination program is well under way; on-the-ground training is being given to local child-care workers; malaria-control projects are now progressing in India, Pakistan, Ceylon, and Thailand; and nutrition demonstrations are being carried out in the Philippine Republic.

UNICEF's contribution of $20,000,000 will be more than matched by the governments of the assisted countries, for they will bear most of the cost of operating the programs. UNICEF's contribution will be used mainly for supplies and equipment.

Medical center offers service for adolescents

A special unit for adolescents has been established by the Children's Medical Center, Boston, with Dr. J. Roswell Gallagher in charge. For several years the staff of the center

has recognized that there is a need for special medical service for adolescents, who usually are cared for in surroundings intended primarily for younger children or adults. In initiating facilities for the exclusive use of adolescents the center will provide for these older boys and girls the sort of special attention that it gives to infants and young children.

The staff of the center and all its laboratory and research facilities will be available for the care and study of this age group and its special problems. Hospital care, outpatient service, and consultation service on all types of illness will be provided. The unit will give particular attention to the conditions and problems that are most troublesome in the adolescent years, such as contagious diseases, athletic injuries, psychological problems, growth, and glandular disturbances, as well as reading and other scholastic difficulties.

From the National Institute of Mental Health

Nine States have advanced to the point of having separate institutions not only for the mentally diseased but also for mental defectives and for epileptics. These States are: Indiana, Kansas, Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, and Texas. Most other States care for epileptics in the same institutions as mental defectives, although their needs are usually quite different. Three States care for these two groups only in hospitals for mental diseases, even though mental defectives and epileptics are not mentally ill. These States are Arkansas, Arizona, and Nevada.

About 80 percent of mental defectives admitted during 1948 for the first time to one of the 94 State institutions that reported for that year to the National Institute of Mental Health of the Federal Security Agency were under 20 years of age; their median age was 13.2 years, the girls having a slightly higher median age than the boys.

The median age of epileptics admitted to these institutions for the first time that year was 18.3 years, or 5.1 years higher than that for mental defectives. The median for girls and boys showed only a little difference in age.

A rough index of the adequacy of care provided by these institutions is the ratio of patients to full-time employees. Figures compiled by the National Institute of Mental Health show that 1948's ratio is a slight improvement over 1947's.

For interstate shipment of milk.

A decision of the U. S. Supreme Court that invalidates a provision of the local ordinance of a Wisconsin city restricting the sale of milk not pasteurized within a stated distance from the city center will undoubtedly affect other ordinances that prevent the shipment of milk across State lines.

The Supreme Court found that the city "even in the exercise of its unquestioned power to protect the health and safety of its people," cannot, by ordinance, discriminate against milk shipments "if reasonable nondiscriminatory alternatives, adequate to conserve legitimate local interests, are available."

The Court pointed to the existence of the milk ordinance and code recommended by the Public Health Service, which, the court said, "imposes no geographical limitations on location of milk sources and processing plants but excludes from the municipality milk not produced and pasteurized conformably to the standards as high as those enforced by the receiving city."

The recommended milk ordinance has already been adopted voluntarily by many localities. To encourage these communities to attain and maintain a high level of excellence in enforcing the ordinance, the Public Health Service publishes a list of counties and municipalities that under the ordinance have a milk rating of 90 percent for both pasteurized and raw milk marketed within its limits. The list as recently published contains the names of 160 cities and counties in 20 States.

●

"The protection of childhood is costly. The standards we are willing to accept and carry forward are a test of democracy because they are a test of whether it is the popular will to pay the cost of what we agree is essential to the wise and safe bringing up of children."

Julia C. Lathrop, 1919

• FOR YOUR BOOKSHELF

JUVENILE COURT STATISTICS 1946–1949. Children's Bureau Statistical Series No. 8. Federal Security Agency, Social Security Administration, Children's Bureau, Washington. 1951. Processed. 16 pp. Single copies free.

About 12 in every 1,000 children in the Nation between the ages of 7 and 17 came to the attention of juvenile courts in 1949 because of delinquency, according to this most recent of the Children's Bureau statistical reports on juvenile delinquency.

The year saw a 4-percent increase in juvenile-court delinquency cases over 1948, and the reversal of a downward trend that started with the end of World War II. During this period, the number of children in the 7-to-17 age group in the general population remained relatively constant.

The study, which includes not only juvenile-delinquency cases, but also cases of dependency and neglect, as well as "special proceedings," is based on reports from 413

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courts in 22 States in 1949. Of these, 218 courts in 15 States have reported on such cases regularly since 1946.

Reports of juvenile-court activity have been published by the Bureau since 1927.

The 413 courts reported a total of 70,616 juvenile-delinquency cases disposed of during 1949. Of this number 58 percent were disposed of unofficially, either after conference or after more intensive social investigation and study.

The study shows the median age of children involved in delinquency cases to be about 15½ years for both boys and girls. Almost 75 percent of the children involved were 14 years of age or older. Boys' cases outnumbered girls' cases by about four to one.

However, a larger percentage of boys than of girls were permitted to remain with their parents pending court decisions. Sixty-three percent of the boys' official cases were handled in this manner, as compared with only 43 percent of the girls'. The difference is related to the reasons for which girls are brought to court, such as sexual promiscuity with its dangers of venereal disease, pregnancy, and so forth. Such misconduct is considered serious enough to require detention in order to protect both the community and the girls.

Ever since the juvenile-court movement began, at the opening of this century, efforts have been made to keep children out of jails, where they frequently have been detained along with adult criminals. Many States now have laws to prohibit jail detention of children. However, the Children's Bureau study shows that in 25 percent of the delinquency cases of children who were detained overnight or longer the child was detained in jail. Usually this method was used because of the lack of suitable detention facilities, particularly in some small towns and rural areas.

The report shows that 218 juvenile courts that reported on dependency and neglect cases during the period from 1946 through 1949 showed an 8-percent decrease in such cases during that period. This decrease may reflect both the high level of employment during the postwar years and the elimination or improvement of many war-associated conditions. The return of fathers from the service and the drop in the number of working mothers made for more normal family life.

Of the total children's cases handled by the 413 courts reporting in 1949, approximately 24,000, or about 24 percent, were cases of dependency and neglect. The median age for children dealt with in such cases was 6½ years; 70 percent of the children involved in dependency and neglect proceedings were under 10 years of age.

A reflection of the increased number of children adopted in the last several years is shown in the 13-percent increase in "special proceedings" cases from 1946 to 1949. Adoption proceedings account for a large part of such cases.

Juvenile-court statistics are gathered on a calendar-year basis. Data on 1950 are currently being gathered, although reports have not been received as yet from all agencies. The upward trend begun in 1949 seems to have continued in 1950, these preliminary figures show.

The report includes a statement calling attention to the limitations of the study. Part of this statement is as follows: "Because of their limitations, juvenile-court statistics alone do not provide a reliable index of the extent of delinquency problems or dependency and neglect situations. In regard to the extent of such problems, they may be particularly misleading when used to make comparisons between one community and another."

OCCUPATIONAL CHOICE; an approach to a general theory. By Eli Ginzberg, Sol W. Ginsburg, M.D., Sidney Axelrad, and John L. Herma. Columbia University Press, New York, 1951. 271 pp. $3.75.

Occupational choice is viewed by these authors as a developmental process. The process, they tell us, begins with a "fantasy stage," in childhood. It continues through a long period of tentative choices, lasting from about 11 years of age up to 18 or 19. And it culminates in a later period of crystallization in which the young person is faced with the necessity of deciding on his occupation.

Since each decision that the boy or girl makes during adolescence is related to his experience up to that point, and in turn influences his future, the authors believe that the process of decision-making is basically irreversible. They believe also that the choice itself, in the period of crystallization, has the quality of a compromise, since the young person has to balance realities against his interests and values. Age 17 the authors consider pivotal, as it is the lowest age at which most young people are ready to strike a balance between these usually conflicting factors.

Looking into the question of family background, the book calls attention to the disadvantages of good students whose families are in a lower-income group, noting that these boys and girls are handicapped by lack of stimulation and guidance toward carrying forward their education, as well as by financial problems.

Provocative suggestions are made concerning the part that parents play, or are unable or reluctant to play, in contributing to the occupational choice of a son or daughter. The book raises searching questions for educators in regard to the age at which young people are expected to make curriculum choices that will narrow their range of vocational choice in the future.

Anyone interested in adolescent development or in vocational counseling should find this analysis suggestive.

The investigations upon which the authors' conclusions are based form part of a larger study of the economics of human resources.

Elizabeth S. Johnson

The Child now $1.25 a year

The Superintendent of Documents, Government Printing Office, has found it necessary to increase the price of THE CHILD, beginning with the issue for November 1951. The price of a year's subscription is now $1.25; foreign postage 25 cents additional. Foreign postage must be paid on all subscriptions sent to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions. Single copies, 15 cents.

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CALENDAR

Dec. 3–4. National Social Welfare Assembly. Seventh annual meeting. New York, N. Y.

Dec. 4–6. National Conference on Labor Legislation. Eighteenth annual meeting. Washington, D. C.

Dec. 5–8. Third Pan American Congress of Pediatrics. Montevideo, Uruguay.

Dec. 11–19. Fourth International Congress on Mental Health. Mexico City.

Dec. 26–29. American Economic Association. Sixty-fourth annual meeting. Boston, Mass.

Dec. 26–31. American Association for the Advancement of Science. One hundred and eighteenth annual meeting. Philadelphia, Pa.

Dec. 27–28. Society for Research in Child Development. Annual meeting. In conjunction with the American Association for the Advancement of Science. Philadelphia, Pa.

Dec. 27–29. American Speech and Hearing Association. Twenty-seventh annual meeting. In conjunction with the Speech Association of America. Chicago, Ill.

Dec. 27–29. American Statistical Association. One hundred and eleventh annual meeting. Boston, Mass.

Area conferences, National Child Welfare Division, American Legion:

Dec. 6–8, 1951. Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Las Vegas, N. Mex.

Jan. 11–12, 1952. Area D—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Des Moines, Iowa.

Feb. 1–2, 1952. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Charleston, W. Va.

Mar. 6–8, 1952.—Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Little Rock, Ark.

Mar. 14–15, 1952. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Portland, Me.

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